STAR Kids
Long Term Services and Supports

Revised: 071122

Cook Children's Health Plan

Table of Contents

Cook Children's Health Plan

Our Promise

Knowing that every child's life is sacred, it is the Promise of Cook Children's to improve the health of every child through the prevention and treatment of illness, disease and injury.

Cook Children's Health Plan

Provider Support Services

888-243-3312

A representative is available Monday – Friday, 8am-5pm, excluding State holidays.

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Benefits, Limitations and Exclusions

Providers should verify benefits, limitations and exclusions located in the Texas Medicaid Provider Procedures Manual (TMPPM) at tmhp.com prior to rendering services. Always refer to the most recent publication.

When submitting services for reimbursement Providers should refer to the most recent publications of the:

- Texas Medicaid Provider Procedures Manual located at tmhp.com
- Cook Children's Health Plan Provider Manuals located on cookchp.org
- Electronic Data Interchange Requirements located on tmhp.com and cookchp.org
- CPT/ICD-10/HCPC coding books
- Medicaid National Correct Coding edits located on CMS.gov and Medicaid.gov

Cook Children's Health Plan

STAR Kids

Veronica Riddell

Manager, Service Coordination

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What is STAR Kids?

It is a program mandated through Senate Bill 7, 83rd Legislature, Regular Session, 2013 to provide Medicaid benefits to children and adults 20 and younger with disabilities.

- The program is administered through Managed Care Organizations (MCO)
- STAR Kids Program is mandated for children and youth meeting eligibility criteria
- The program provides comprehensive medical benefits, behavioral health benefits, and service coordination

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STAR Kids Program Goals

- Create an integrated program that addresses a Member's acute and functional needs through Person Centered Planning in the least restrictive environment
- Use MCO directed Service Coordination model to coordinate care and services to improve coordination of delivery of care to recipients, improve access to services and promote overall positive health outcomes
- Provides a coordinated plan of transitioning youth from childhood programs to adult Long Term Services and Supports (LTSS) programs such as STAR+PLUS

STAR Kids Eligibility

Participation in the STAR Kids program is required for those who are 20 and younger, covered by Medicaid, and meet at least one of the following:

- Get Supplemental Security Income (SSI)
- Get SSI and Medicare
- Get services through the Medically Dependent Children Program (MDCP) waiver
- Get services through the Youth Empowerment Services (YES) waiver
- Live in a community-based intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) or nursing facility
- Get services through a Medicaid Buy-In program

STAR Kids Eligibility

- Get services through any of the following intellectual and developmental disability (IDD) waiver programs
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities (DBMD)
  - Home and Community-based Services (HCS)
  - Texas Home Living (TxHmL)

STAR Kids Covered Services

Include Medically Necessary:

- Therapy
  - Speech, Occupational, & Physical
- Durable Medical Equipment
- Medical Supplies
- Private Duty Nursing
- Skilled Nursing Visits
- Nutritional Counseling
- Counseling services with a licensed professional
- Orthotics
- Prosthetics
- Vision
- Hearing
- Inpatient Psychiatric Services
- Inpatient Rehabilitation
- Extended Hospitalization

STAR Kids Acute Services

STAR Kids provides acute services which includes preventive and medically necessary care along :

- Nursing services
- Hospital visits
- Primary care
- Durable Medical Equipment
- Therapies

Long Term Services and Supports

- LTSS is defined as home and community based services and supports, used by individuals with functional limitations and chronic illnesses who need assistance to support living in an community setting versus a facility or institution
- LTSS services include help with performing routine activities of daily living and instrumental activities of daily living such as bathing, dressing, preparing meals, and administering medications
- LTSS services were created to alleviate/reduce high health care costs by providing services to enhance an individuals ability to reside in a home or community environment

Long Term Services and Supports

Long-Term Services & Supports (LTSS) provides assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability.

There are a few different types of LTSS services offered to Members who meet the qualifications to receive them:

- Personal Care Services (PCS)/Personal Attendant Care (PAS)
- Community First Choice (CFC)
- Habilitation (HAB)
- Emergency Response Services
- Support Management
- Medically Dependent Children's Program Services (MDCP)

Personal Care Services

- Personal Care Services (PCS) is a non-skilled service
  - It's Attendant Care
- Non-technical Personal Care Services (PCS) for those whose health problems impair their ability to perform Activities of Daily Living (ADLs)
  - Examples of ADLs: Bathing/dressing, meal prep, feeding, eating, cleaning, laundry, shopping
- PCS includes:
  - Medication administration when appropriate
  - Assistance with adaptive or assistive devices
  - Assistance with the use of Durable Medical Equipment (DME)
  - Set-up, supervision, cueing, prompting, and guiding when provided as part of the hands-on assistance with qualifying ADLs

PCS Limitations and Considerations

- Individuals in a hospital, nursing facility or Intermediate Care Facility with Intellectual or Developmental Disabilities (ICF-IID) are not eligible for PCS
- The Legal Authorized Representative (LAR), spouse of LAR, designated representative (DR) or spouse of DR cannot be the attendant
- PCS hours cannot be banked
- PCS is not a benefit for laundry for a Member's family or household, but may be permissible when related to Member's diagnosis or condition (e.g. incontinence etc.)
- PCS does not include Habilitation (HAB) or Emergency Response Services

Personal Care Services

Process for initiating and continuing PCS services:

- Practitioners Statement of Medical Need(PSON) must be completed yearly
- STAR Kids Screening Assessment Instrument (SAI) completed including the Personal Care Assessment Module (PCAM)
- Person centered planing to determine services

Community First Choice
&
Medically Dependent Children Program

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Manager, Service Coordination

Cook Children's Health Plan

Community First Choice

Community First Choice (CFC) Personal Assistance Services (PAS) is Attendant Care.

- Provides assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) through hands-on assistance, supervision, and/or cueing

Includes:

- Non-skilled assistance with the performance of ADLs and IADLs
- Household chores necessary to maintain the home in a clean, sanitary, and safe environment
- Escort services, which consist of accompanying, but not transporting, and assisting a Member to access services or activities in the community

Community First Choice

- Assistance with health-related tasks
  - Health-related tasks, in accordance with state law, include tasks delegated by a registered nurse, health maintenance activities, and extension of therapy

Note: Community First Choice Personal Assistance Service hours cannot be banked.

Community First Choice

CFC is also Habilitation, Emergency Response and Support Management:

- Habilitation (CFC-HAB):
  - Face-to-face training on self-care to allow an individual to live successfully in a community setting
  - Training may cover activities such as personal hygiene, mobility, household tasks, use of adaptive equipment, self-administration of medications, and community integration
- Emergency Response Services:
  - Provides reimbursement for electronic devices to ensure continuity of services and supports for individuals who live alone or are alone for extended periods of time
  - This service connects a member to an ERS provider who notifies local authorities, like paramedics or a fire department, to a member's emergency
  - This service is not routinely authorized for members who are minors

Community First Choice

- Support Management (Support Consultation):
  - Voluntary training on selecting, managing, and dismissing attendants
  - Support management is available to any Member receiving CFC services, regardless of the selected service delivery model

Note: Community First Choice Habilitation hours cannot be banked.

Qualifications for CFC

- Physician completes the Form 2601 certifying the applicant requires ongoing nursing services under the direction of a physician in a home or community-based setting program or in a facility
- Meets medically necessity criteria for institutional level of care, assessed by the Local Intellectual and Developmental Disability Authorities (LIDDAs) and meets institution level of care or is a MDCP or YES waiver recipient
  - The local LIDDA will conduct a Determination of Intellectual Disability for Members with IDD diagnosis to assess for eligibility for CFC
  - The LIDDA provides Service Coordination to individuals who receive CFC services and also proposes a plan of care

Medically Dependent Children Program

Medically Dependent Children Program (MDCP) provides services to support families in caring for Members until age 21, who are medically dependent as an alternative to receiving services or residing in a nursing facility.

- Encourages de-institutionalization of children in nursing facilities
- Provides a specific range of services in limited amounts
- STAR Kids Screening and Assessment Instrument is conducted at least annually for Members on MDCP
  - Services are approved based on the Member's needs determined by the parents, Members, and Service Coordinators and are dependent on the yearly budgets
    - Budget or Resource Utilization Group (RUG) is determined by the state based upon meeting medical necessity
- State assigned budget can be utilized for respite care (RN, LVN, Attendant), Minor Home Modifications, or Adaptive Aids

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Medically Dependent Children Program

Services available for MDCP recipients include:

- Adaptive Aids
  - Items necessary to treat, rehabilitate, prevent or compensate for conditions resulting in disability or loss of function
  - Adaptive Aids also may be devices enabling a person to perform the activities of daily living or control the environment in which they live.
- Employment Assistance
  - Assistance to help a person find paid employment in the community
- Minor Home Modifications
  - Necessary physical modifications of a person's home to prevent institutionalization or support de-institutionalization
  - The modifications must be necessary to ensure health, welfare and safety or to enable greater independence in the home

Medically Dependent Children Program

- Financial Management Services
  - Assistance delivered by a consumer directed services agency
- Flexible Family Support Services
  - Individualized and disability-related services, including personal care supports for basic Activities of Daily Living (ADL), Instrumental ADL, skilled care and delegated care supports, to:
    - Assist a child to participate in child care
    - Assist a person to participate in post-secondary education
    - Increase a person's independence
- Respite Services
  - Temporary relief for the primary caregiver from their caregiving role during times when the caregiver would normally provide care

Medically Dependent Children Program

- Respite can be provided by:
  - Attendants
  - Nurses (LVNs/ RNs)
- The amount of respite services authorized do not take into account for services authorized for CFC or Private Duty Nursing (PDN)
- Respite services are to provide the parent or guardian additional time to preform daily or personal activities (not including going to work or school)
  - Out-of-home respite is limited to 29 days annually
  - Camp
    - Special Health Care Needs Camp (SHCN)
    - Up to $200 per member for joining an approved SHCN camp, the benefit is one per year

Medically Dependent Children Program

    - In-home respite is limited by the amount of the Member's cost limit (RUG)
  - Must be provided in the state of Texas
  - Respite may not duplicative or replace other nursing services
- Supported Employment
  - Assistance to sustain competitive employment for a person who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform work in a setting at which people without disabilities are employed
- Transition Assistance Services
  - A one-time service offered to transition Members from a long term care facility into their home or community based setting

Authorizations

- Hours are authorized using person centered planning with the parent/ guardian (Legally Authorized Representative(LAR)), Member, and Service Coordinator based on the yearly budget (RUG)
- Hours for respite can be banked within the same plan year but cannot be carried over to another plan year
- Authorizations are completed based upon the Member's assigned plan year
  - One (1) full year – three hundred sixty-five (365) days

Authorizations

- MDCP authorizations (respite, adaptive aids, home modification, etc.) might end prior to one year if the Member:
  - Is no longer eligible for MDCP
  - Changes to a new waiver
  - Does not meet the medical necessity criteria for MDCP
  - Turns twenty-one (21) and ages out of the program
    - Authorizations will end at 11:59PM the day before the Member turns twenty-one (21)
  - Moves out of the service delivery area
  - Elects not to receive the services any longer
  - Selects a new MCO

Authorizations

- All LTSS authorizations (CFC, PDN, therapy) will end the last day of the month they turn twenty-one (21)
  - Medicaid services run through the end of the Member's birthday month that they turn twenty-one (21)
- Authorizations can be updated throughout the year if the Member's budget needs to be recalculated for adaptive aids or minor home modifications
  - Ideally, we try to budget for these at the beginning of the Member's plan year, but does not always occur that way

Service Delivery Options

There are three (3) service delivery options for Personal Care Services, Consumer First Choice and Respite:

- Agency
- Consumer Directed Services
- Service Delivery Option

Agency:

- The MCO contracted agency is responsible for managing the day-to-day activities of the attendant and all business details

Service Delivery Options

Consumer Directed Services (CDS):

- The CDS option allows the Member or legally authorized representative (LAR) to be the employer of the service provided
  - There are some restrictions regarding whom can or cannot be a service Provider
- Financial Management Service Agency (FMSA) is responsible for all business aspects of employment

Service Delivery Option:

- The Member or LAR directs most day-to-day activities and the contracted Home Community Support Services Agency (HCSSA) is responsible for managing all business details

FMSA Responsibilities

A Financial Management Services Agency (FMSA) must provide financial management services to a Consumer Directed Services (CDS) employer or designated representative, including:

- Orienting and training about CDS employer responsibilities for the CDS option, including legal requirements of various governmental agencies
- Assisting with and approving budgets for each service to be delivered
- Completing forms required to obtain an employer identification number (EIN) from federal and state agencies
- Conducting criminal history checks and registry checks of applicants
- Verifying each applicant's eligibility with program requirements, including Medicaid fraud exclusions, before an applicant is employed or retained by the CDS employer
- Registering as the employer-agent with the Internal Revenue Service (IRS) and assuming full liability for filing reports

FMSA Responsibilities

- Paying employer taxes, on the CDS employer's behalf, to the IRS and Texas Workforce Commission
- Receiving and processing employee time sheets, computing and paying all federal and state employment-related taxes and withholdings, and distributing payroll at least twice a month
- Receiving and processing invoices and receipts for payment
- Maintaining records of all expenses and the reimbursement and monitor budget
- Submitting claims to the Member's Managed Care Organization (MCO)
- Providing written summaries and budgeting balances of payroll and other expenses at least quarterly
- Preparing and filing employer-related tax and withholding forms and reports (this does not include filing personal income tax returns for employees)
- Providing ongoing training and assistance, as needed or requested

FMSA Responsibilities

- Must obtain employer-agent status, as defined by IRS Rev. Proc., 2013-39, and perform all responsibilities as required by the IRS, Texas Workforce Commission other appropriate government agencies
- Enters into service agreements with each of the Member's direct service Providers before issuing payment
- May not provide Financial Management Services (FMS) and case management services to the same Member
- Must participate in all mandatory training provided or authorized by the Texas Health and Human Services Commission

Note: The MCO must monitor the FMSA's performance and must ensure the FMSA performs all FMSA responsibilities, including participation in mandatory training.

Allowable and Non-Allowable Expenditures

Appendix XI
Allowable and Non-Allowable Expenditures*

Allowable Expenditures	
Compensation – Wages and Payments	**Payroll Taxes – Employer and Employee Shares (as applicable)**
Salaries and Wages	FICA – Social Security and Medicare
Employee Share of Taxes and Withholdings	Income Tax
Employer Share of Taxes and Withholdings	**Workers' Compensation Related Expenses**
Regular Time	State Workers' Compensation Premiums
Overtime Pay (for hours worked in excess of 40 hours/week)	Paid Claims for Employee (work-related injuries and illnesses)
Compensation of Approved Contracted Program Services	Insurance Premiums (employee work-related injuries and illnesses)
Compensation – Employee Benefits (Taxed)	**Employer Support Expenditures**
Bonus (hire-on, longevity, performance)	Advertising/Employee Recruitment
Vacation Leave	Employee Training
Sick Leave	Criminal History Checks (at actual cost only)
Other Leave (jury duty, funeral, etc.)	Equipment – ***must be employer/employment-related*** (e.g., internet service, fax machine, printer, phone or computer needed to complete employer/employment-related duties)
Employee Insurance Premiums (life)	Employer-Related Mailing Costs
Employee Mileage Reimbursement (e.g., commuting – not related to direct consumer services) ***CLASS Only***	Employee Mileage Reimbursement (related to delivery of consumer services; employee is not taxed)
Employee Insurance Premiums and Paid Claims (health, medical, dental, disability)	Supplies (e.g., gloves)
	Uniforms (e.g., employee aprons)
Employer-Paid Contributions to Employee Deferred Compensation Plans, Retirement/Pension Plans, Child Day Care, Accrued Leave	Hepatitis B Vaccinations
	Copy Expenses
Payroll Taxes – Employer and Employee Shares (as applicable)	Travel Costs (other than mileage reimbursement) ***CLASS Only***
Federal Unemployment Taxes (FUTA)	**Court-Ordered Garnishments** (alimony, child support, guaranteed education loans, etc.) ***and*** **Employee Voluntary Withholdings/Accruals**
State Unemployment Taxes (SUTA)	
Federal, State and Local Taxes	

Non-Allowable Expenditures	
Program Specific	**Other Excluded Expenses**
Refer to the program rules and provider manual	Services, goods, items or supports provided to or benefiting someone other than the person receiving services
Third-Party Resources	
Services covered by the State Medicaid Plan, Medicare, private insurance, public education, home-based schooling, community resources, and other sources of assistance and support	Personal need items
	Services beyond the scope of the program service definition
	Room and board beyond the rate paid to a facility approved for out-of-home respite services
Fees and Assessed Penalties	Expenses related to unpaid caregivers
Late Fees and Assessed Penalties	Expenses related to a Designated Representative (DR)
Finance Charges	Expenses related to the spouse of the person receiving services, employer or DR
Stop Payment Cost	

* List is **not** all-inclusive.

Texas Health and Human Services Commission
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Cook Children's Health Plan

Reminders

LTSS Claim Submission

All Long Term Services and Supports must be billed on a CMS 1500 claim form or the HIPAA 837 Professional Transaction.

Electronic Claims:

- Electronic Data Interchange
  - 837P (LTSS Home/Community Services) format
- Availity Clearinghouse
  - www.availity.com
  - Availity Client Services (800) 282-4548
  - Plan Payer Identification: Payer ID: CCHP9

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Date Span Billing

Cook Children's Health Plan does not allow date span billing.

- Each date of service must have it's own claim line

Timely Filing Deadline

Timely filing

- Initial claim must be received by the health plan within 95 days of the date of service
  - If the claim covers multiple dates, the 95 day timely filing is based on the FIRST date of service on the claim form
- Secondary claims must be received by the health plan within 95 days from the disposition date on the primary insurance Explanation of Benefits (EOB)
- Corrected claims must be received by the health plan within 95 days of the date of service

STAR Kids Billing Matrix

Bill and report Long Term Services and Supports in compliance with the STAR Kids Billing Matrix.

LTSS Billing Matrix and Crosswalk

- Appendix III, LTSS Billing Matrix and Crosswalk
- **New Billing Matrix changes coming in September 2022**

Authorization/Referral letter:

- LTSS Providers must review and abide by the authorization/referral letter that includes dates of services, units, and modifiers
- LTSS Providers must not go over units without getting approval from the STAR Kids Service Coordinator
  - Failure to do so will result in denial of the claim and can lead to a Corrective Action Plan

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STAR Kids Billing Matrix

Modifiers

- LTSS Providers must use the "designated position" of the modifiers as indicated on the STAR Kids Billing Matrix when filing claims
  - Failure to do so will result in denial of the claim

Note: Authorization dates of service, procedure codes, place of service, and modifiers must match the services as billed on the claim form.

LTSS Payment Rates

To locate Long Term Services and Supports payment rates visit:

- https://pfd.hhs.texas.gov/

Authorization Number – Claim Form

If an authorization is required for the service you provided you must submit the claim form with the authorization number in the appropriate field. **Claims submitted without the authorization number will be denied.**

Paper Claim Form

- CMS 1500
  - Item 23

Electronic Data Interchange

- Loop 2300, Segment REF

Provider NPI and Taxonomy Code

Each claim must include the National Provider Identifier, Taxonomy code and qualifier for the following Providers, when applicable:

- Rendering Provider
- Billing Provider
- Supervising Provider
- Referring Provider
- Ordering Provider
- Service Facility Location

Reminder: You must enter the Provider's complete first name and last name.

Provider NPI and Taxonomy Code

The Provider Name, NPI and Taxonomy must match the way the Provider is enrolled and attested with Texas Medicaid.

- Login to your profile on tmhp.com to verify your attestation

Reminder: When filing a claim Providers must use the NPI and Taxonomy codes as enrolled and attested with Texas Medicaid. Claims submitted without the appropriate NPI and Taxonomy code will be rejected or denied.

Claim Number Sequence

Cook Children's Health Plan's claim number sequence includes the date the claim was received.

Here is an example of the claim number format:

- 21040100001
  - YYMMDD + 5 digit claim system generated ID

Note: Claims are adjudicated within 30 days of the date the health plan received the claim.

Secure Provider Portal

Cook Children's Health Plan offers an online portal where Providers can access clinical or managed care data.

By granting Providers access to Epic over the web the amount of paper authorizations, manual claim status requests, and customer service calls are reduced.

Visit cookchp.org to register for our new Secure Provider Portal.

- Select request new account and follow the steps
- 3 - 5 business days for the account to be approved
- You will receive an email confirming your registration

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Secure Provider Portal

Each Provider office must have a Site Administrator.

- The Site Admin will be responsible for submitting account requests for each staff member who requires access and deactivating users who resign or are terminated
- Each staff member must have their **own** unique user name and password

Need assistance in navigating the Secure Provider Portal?

- Register for a webinar by visiting the Provider Relations page located on cookchp.org, select the Provider Training Webinar Schedule
  - Review the calendar and follow the instructions to register for the webinar of your choice

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EFT and ERA

Providers must elect to receive Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) for all Cook Children's Health Plan claim payments.

Detailed enrollment information can be found on the Provider Relations page as well as the Electronic Submission Services page located on our website at cookchp.org.

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Access & Availability

Managed Care Organizations are contractually and financially responsible for meeting Health and Human Services (HHS) access standards.

Health plans are required to verify that covered services furnished by network Providers are available and accessible to Members.

For this reason Cook Children's Health Plan conducts an Access and Availability survey of all Provider types once every fiscal year.

Access to Primary Care Providers, Specialty Care Providers, Ancillary Providers and Network Facility Providers must be available to Members for routine, urgent and emergent care.

- Providers must keep their demographic information current with the health plan
- Providers must provide a response to a Member's after-hours call within thirty (30) minutes

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Access and Availability

During regular office hours, Providers should make every effort to:

- Answer the telephone within 5 rings or 30 seconds
- Respond to non-urgent voicemails within 4 hours
- Not exceed a hold time of 3 to 5 minutes without giving the Member the opportunity to continue to hold or leave a message

Please adhere to the following regulatory standards:

LEVEL/TYPE OF CARE	TIME TO TREATMENT (CALENDAR DAYS)
Specialty Urgent Care	Provided within 24 hours
Specialty Routine Care	Provided within 21 days
Long-Term Services and Supports (LTSS)	Must be initiated within 7 days from the start date on the Individual Service Plan (ISP) OR the eligibility effective date for non-waiver LTSS unless the referring provider, Member or Handbook says otherwise
Prenatal care	Must be provided within 14 days
High-risk pregnancies or new Members in the third trimester	Must be offered within 5 days, or immediately if an emergency exists

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